MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 837 DENTAL CLAIM ADDENDA VERSION 4010A1

June 26, 2006

Effective for Claims Submitted On or After May 1, 2006

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim Addenda, ASC X12N 837 (004010X097A1)**, dated October 2002 and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837 (004010X097)**, dated May 2000. This document should be used in conjunction with all MDCH claim submission and claim processing guidelines. The document follows guidelines authorized in the Final Rule by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm)

NOTE: ***Page references*** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837 (004010X097)** ("Version 4010"), unless otherwise noted (with an asterisk(*)) as referring to the Addenda Implementation Guides ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim Addenda, ASC X12N 837 (004010X097A1)**.

Page*	Loop	Segment	Data Element	Comments
53		ST – Transaction Set Header		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE), as recommended by the HIPAA-mandated implementation guide.
56		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use “CH” (Chargeable).
11*		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X097A1” if using the October 2002 Addenda Implementation Guide.
61	1000A – Submitter Name	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender’s Code).
67	1000B – Receiver Name	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
69	2000A – Billing/Pay-to Provider Hierarchical Level	HL – Hierarchical Level	HL01 – Hierarchical ID Number	HL01 must begin with “1” and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Use the EIN or SSN value assigned to the MDCH provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier).
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number).
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider’s Secondary Identification Number	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
99	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	Use “P” if MDCH is the only payer (that is, patient has no other insurance), “S” if there is one other payer, or “T” if there are two or more other payers.

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101	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use “MC” for Michigan Medicaid, “11” for CSHCS (Title V) and State Medical Plan (Other Non-Federal). If beneficiary qualifies for more than one program or other MDCH program not listed, use “MC”.
105	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use “MI” (Member Identification Number).
106	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient’s 8-digit beneficiary ID number assigned by MDCH.
118	2010BB – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use “PI” (Payor Identification).
118	2010BB – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use “D00111” for MDCH.
132	2000C – Patient Hierarchical Level			MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect providers to submit any Loop 2000C (Patient Hierarchical Levels) in a transaction set. Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected.
149	2300 – Claim Information			Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 claim information within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Levels) will be rejected.
151	2300 – Claim Information	CLM – Claim Information	CLM05-1 – Facility Code Value	Place of service codes as defined by the Center for Medicare and Medicaid Services (formerly HCFA). See cms.hhs.gov/state/poshome.asp
151	2300 – Claim Information	CLM – Claim Information	CLM05-3 – Claim Frequency Type Code	Use “1” on original claim submissions; use “7” for claim replacement, and use “8” for claim void/cancel. For both “7” and “8”, include the original CRN, as indicated in Loop 2300 REF (Original Reference Number (ICN/DCN)).
180	2300 – Claim Information	REF – Original Reference Number (ICN/DCN)	REF01 – Reference Identification Qualifier	When submitting a claim replacement or claim void/cancel (as indicated by Loop 2300 CLM05-3 (Claim Frequency Type Code)), use “F8”.
180	2300 – Claim Information	REF – Original Reference Number (ICN/DCN)	REF02 – Claim Original Reference Number	Use the 10-digit CRN assigned by MDCH to the last approved claim.

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17*	2300 – Claim Information	REF – Prior Authorization or Referral Number	REF01 – Reference Identification Qualifier	When submitting a Prior Authorization number, use "G1" (Prior Authorization Number).
17*	2300 – Claim Information	REF – Prior Authorization or Referral Number	REF02 – Referral Number	Use the 9-digit Prior Authorization number assigned by MDCH.
186	2300 – Claim Information	NTE – Claim Note	NTE01 – Note Reference Code	Use "ADD".
186	2300 – Claim Information	NTE – Claim Note	NTE02 – Claim Note Text	Provide free-text remarks, if needed
195	2310B – Rendering Provider Name			This loop will normally not be used since MDCH expects the billing provider to be the rendering provider (Loop 2000A – Billing/Pay-to Provider Hierarchical Level).
209	2320 – Other Subscriber Information	SBR – Other Subscriber Information		If the patient has other insurance (Medicare, for example), repeat this loop for each other payer. Do not put information about MDCH coverage in this loop.
210	2320 – Other Subscriber Information	SBR – Other Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has other insurance, report primary payer coverage with code "P" and any other insurance with codes "S" or "T", as appropriate.
210	2320 – Other Subscriber Information	SBR – Other Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient's relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father's insurance, use code "19" (Child).
210	2320 – Other Subscriber Information	SBR – Other Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
211	2320 – Other Subscriber Information	SBR – Other Subscriber Information	SBR09 – Claim Filing Indicator Code	Do not use "MC" (Medicaid) in this element.
232	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix	Use the name of the subscriber as it appears on the files of the other payer.
233	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use "MI" (Member Identification Number).

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Page*	Loop	Segment	Data Element	Comments
233	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the other payer indicated in Loop 2330B (Other Payer Name). For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
238	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use "1W" (Member Identification Number).
241	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use "PI" (Payor Identification).
241	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	Use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if Delta Dental is the Other Payer, the value (carrier code) carried in this element would be "03085010."
259	2330D – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use "1D" (Medicaid Provider Number).
263	2330E – Other Payer Rendering Provider	REF – Other Payer Rendering Provider Identification	REF01 – Reference Identification Qualifier	Do not use "1D" (Medicaid Provider Number).
268	2400 – Line Counter	SV3 – Dental Service	SV304 – Oral Cavity Designation	For dates of service on and after May 1, 2006, the Oral Cavity Code is required on the claim when applicable. Review the Billing & Reimbursement for Dental Providers Chapter for the required data characters. The dental database on the MDCH website lists the procedure codes that require the Oral Cavity Code designation. The data characters required are two-digit numeric characters. They are: 01 is the Maxillary Arch 02 is the Mandibular Arch 10 is the Upper Right Quadrant 20 is the Upper Left Quadrant 30 is the Lower Left Quadrant 40 is the Lower Right Quadrant
270	2400 – Line Counter	SV3 – Dental Service	SV306 – Quantity	MDCH requires a quantity of "1". Use a separate service line for each dental service.
271	2400 – Line Counter	TOO – Tooth Information		MDCH will only process one repeat of Loop 2400 TOO (Tooth Information) per service line. Any additional repeats may be ignored.

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273	2400 – Line Counter	DTP – Date-Service	DTP03 – Service Date	MDCH expects service date on every service line.
301	2430 – Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in Loop 2320 (Other Subscriber Information).

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